MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES

IMPACT ANALYSIS TEMPLATE Refer to ER # 3.01500. *Must be submitted at least 60 days prior to change.*

AGENCY/SITE AFFECTED	AGENCY/SITE NUMBER

1. Caseload per month at location that will close, reduce hours or move. Give the expected caseload if opening a new site.
2. Date of change. Indicate whether the site is opening, closing, reducing hours or moving.
3. Why are you requesting this change? Please be specific.
4. Race and ethnicity of participants at affected site (Information can be obtained from Participation by Priority/Category/Ethnicity Group Report in MOWINS)
5. What type of network connection do you have at this site? (e.g. DSI or satellite)
6. Distance between current location and new location (if applicable)
7. Hours & days of week/ month of operation of clinic (before and after if hours are changing)
8. Number of staff by title that typically staff clinic (e.g. Clerk, nutritionist, etc.)
9. SERVICES PROVIDED AT CLINIC (e.g. Certification, check pickup, etc.)

Plan to maintain services to existing participants- include how you will notify affected participants. If relocating or closing, follow up with no-shows from the site to ensure they know where to go for WIC services. If the site is closing, include disposition of the equipment located at the site.

PLEASE INCLUDE ANY OTHER ADDITIONAL INFORMATION ON A SEPARATE PAGE AND ATTACH.

SIGNATURE	DATE